DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO	DATE
Singleton/Chavis	5-22-13

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER 000368	[ ] Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR cc: Mr. Keck, Dept. Cts file	[ ] Prepare reply for appropriate signature DATE DUE _____ [ ] FOIA DATE DUE _____ [X] Necessary Action

APPROVALS (Only when prepared for director's signature)	APPROVE	* DISAPPROVE (Note reason for disapproval and return to preparer.)	COMMENT
1.			
2.			
3.			
4.			

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Atlanta Regional Office
61 Forsyth Street, Suite 4T20
Atlanta, Georgia 30303

CENTERS FOR MEDICARE & MEDICAID SERVICES

DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS

May 20, 2013

RECEIVED
MAY 22 2013
Department of Health & Human Services
OFFICE OF THE DIRECTOR

Mr. Anthony E. Keck, Director
South Carolina Department of Health and Human Services
Post Office Box 8206
Columbia, South Carolina 29202-8206

Re: Title XIX State Plan Amendment, Transmittal 10-008

Dear Mr. Keck:

We accept your request, dated May 16, 2013, to withdraw South Carolina 10-008. We are returning the form HCFA-179 and proposed plan pages.

If you have any questions or need further assistance, please contact Maria Drake at 404-562-3697.

Sincerely,

Jackie Glaze

Jackie Glaze
Associate Regional Administrator
Division of Medicaid & Children's Health Operations

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

REVISED ON 06-08-11

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: SC 10-008

2. STATE: South Carolina

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
October 1, 2010

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 440.50

7. FEDERAL BUDGET IMPACT: Estimated @ 75.19% for 2011
a. FFY 2011 ($2,706,840)
b. FFY 2012 ($-0-)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19-B Pages 2a.3

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

New Page

10. SUBJECT OF AMENDMENT:
Revise Physician Administered Injectable Drug Fee Schedule Effective Date October 1, 2010

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
Mrs. Forkner was designated by the Governor to review and approve all State Plans

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Emma Forkner

13. TYPED NAME:
Emma Forkner

14. TITLE:
Director

15. DATE SUBMITTED:
September 15, 2010

16. RETURN TO:

South Carolina Department of Health and Human Services
Post Office Box 8206
Columbia, South Carolina 29202-8206

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED:

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:

22. TITLE:

23. REMARKS:

FORM HCFA-179 (07-92)

Injectable drugs administered in a physician office setting will be reimbursed based on a four-tier structure.

Tier 1 is comprised of select generics and injectable drugs in classes with therapeutic alternatives; primarily chemotherapy and supportive agents. It utilizes a variable fee schedule for appropriate reimbursement based on pharmaceutical acquisition costs. A margin is applied to the highest cost drug at between 12 to 15 percent, this margin is then applied to the cost of both the brand and the generic drug. This pricing methodology is based on acquisition cost and total cost of care for alternatives within a therapeutic class.

Tier 2 is comprised of high cost chemotherapy agents and other Non-Oncology Injectable drugs, such as Rheumatoid Arthritis, that exist in brand form only, and are manufactured by one pharmaceutical company. Drugs in this tier will be reimbursed at Average Sales Price (ASP) as published by the Centers for Medicare & Medicaid Services (CMS) plus 6%.

Tier 3 is comprised of all other drugs with ASP pricing that are not included in Tier 1 or Tier 2, these drugs will be reimbursed at ASP plus 10%.

Tier 4 is comprised of all physician administered drugs that do not have ASP pricing, these drugs will be reimbursed based on Average Wholesale Price (AWP) minus 18%.

The provider administered injectable drug fee schedule will be updated and published quarterly; updates will occur January 1, April 1, July 1 and October 1.

For state owned governmental providers which certify expenditures for matching purposes, an annual cost report is submitted each year which provides the cost/utilization statistics of the injectable drugs as well as other state plan service costs. The documented cost of the injectable drugs would include the actual acquisition costs of the drugs along with the application of one-half of the state owned governmental provider's approved indirect cost rate and are accumulated by J code. The total documented injectable drug costs are converted to a cost on a per unit basis and then multiplied by Medicaid units to determine the total allowable Medicaid injectable drug costs. This amount is then compared to the Medicaid fee for service reimbursement to ensure that the costs of the injectable drugs equal to or exceed the Medicaid fee for service reimbursement.

The injectable drug funding methodology described in the paragraph above relating to governmental providers which CPE will end effective June 30, 2011.

Injectable drugs administered in a physician office setting will be reimbursed based on a four-tier structure. The first tier is comprised of select generics and injectable drugs in classes with therapeutic alternatives. It utilizes a variable fee schedule with Maximum Allowable Cost and/or Least Cost Alternative (MAC/LCA) pricing for appropriate reimbursement based on pharmaceutical acquisition costs. The second tier comprises newer chemotherapy agents and higher cost drugs. These will be reimbursed at Average Sales Price (ASP) as published by the Centers for Medicare & Medicaid Services (CMS) plus 6%. All other drugs with ASP pricing will be reimbursed at ASP plus 10 % (Tier 3). Drugs without ASP pricing will be reimbursed based on Average Wholesale Price (AWP) minus 18% (Tier 4). The provider administered injectable drug fee schedule will be updated and published quarterly; updates will occur January 1, April 1, July 1 and October 1.

Effective July 1, 2005, pediatric sub-specialist providers will receive an enhanced Medicaid rate for evaluation & management, medical & surgical procedure codes. These enhanced rates will not exceed 120 percent of the Medicare fee schedule for certain evaluation and management codes as determined by the state agency. All other CPT codes will not exceed 100 percent of the Medicare fee schedule. Pediatric sub-specialist providers are those medical personnel that meet the following criteria: a) have at least 85% of their patients who are children 18 years or younger; b) practice in the field of Adolescent Medicine, Cardiology